

Ret: Liberty Savings, 1900 Indpls Blvd., Whiting, IN

4044 483353 LO

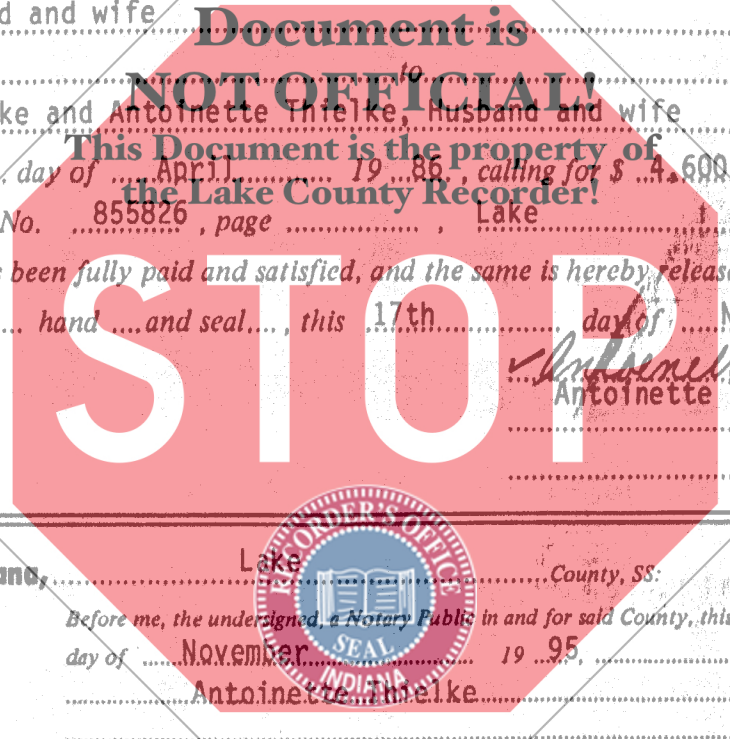
SATISFACTION OF MORTGAGE

This Certifies, That a certain Mortgage executed by J. C. Lay and Patsy Lay, Husband and wife

Paul Thielke and Antoinette Thielke, Husband and wife
on7th..... day ofApril..... 19...86, calling for \$...4,600.00..... and recorded
in Mortgage Record No. 855826, page Lake County
State of Indiana, has been fully paid and satisfied, and the same is hereby released.

WITNESS MY..... hand and seal....., this 17th..... day ofNovember..... 19...95

Antoinette Thielke
Antoinette Thielke



State of Indiana, Lake County, SS:

Before me, the undersigned, a Notary Public in and for said County, this 17th
day ofNovember..... 19...95,
Antoinette Thielke

acknowledged the execution of the annexed satisfaction of mortgage.

Witness my Hand and official seal.

Sherynn Groat
Sherynn Groat, Lake Co. Notary Public.

My Commission expires12/17/96.....

This instrument prepared by: Antoinette Thielke



95 NOV 29 PM 1:20
RECORDED
INDEXED

Chicago Title Insurance Company
STATE OF INDIANA
NEED FOR RECORD

Handwritten initials and date: 12/19/95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. **0501-93**

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1. DECEASED—NAME (First, Middle, Last) Paul Thielke		2. SEX Male	3a. TIME OF DEATH 3:30 P.	3b. DATE OF DEATH (Month, Day, Year) March 1, 1993	
4. SOCIAL SECURITY NUMBER 361-26-3542	5a. AGE—Last Birthday (Years) 56	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) March 16, 1936	
7. BIRTHPLACE (City and State or Foreign Country) Chicago, IL	8a. WAS DECEDENT A U.S. VETERAN? No				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? No		8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not inpatient, give street and number) Broadway Methodist		9b. CITY, TOWN, OR LOCATION OF DEATH Merrillville	9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Antoinette Andres	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Electrician	12b. KIND OF BUSINESS/INDUSTRY LTV Steel		
13a. RESIDENCE—STATE IN	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Griffith	13d. STREET AND NUMBER 812 N. Elmer #5		
13e. ZIP CODE 46319	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) White	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		18. FATHER'S NAME (First, Middle, Last) Erwin Thielke			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Ryan		20a. INFORMANT'S NAME (Type, Print) Antoinette Thielke			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Griffith, IN 46319		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 5, 1993 Holy Cross Cemetery		21c. LOCATION—City or Town, State Calumet City, IL	
22a. EMBALMER'S NAME James Porras		22b. EMBALMER'S LICENSE NO. 1045964	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b. LICENSE NUMBER (of Licensee) 1045184	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #8800135 921 W. 45th Griffith, IN 46319		
26. PART I. DEATH: Enter the disease, injury, or complication that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory failure, shock, or heart failure. List only one cause for each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Primary ventricular fibrillation DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which give rise to the immediate cause, stating the underlying cause last. MAR 09 1993					
PART II. Other significant conditions: Conditions contributing to death but not previously stated in Part I. LAKE COUNTY HEALTH COMMISSIONER					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Phillip S. Chua</i>		29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year) March 4, 1993		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Phillip Chua, M.D. 8684 Conneticut Merrillville, IN 46410					
31. HEALTH OFFICER'S SIGNATURE <i>Phillip S. Chua, MD</i>			32. DATE FILED (Month, Day, Year) March 9, 1993		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			